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Office of Administrative Law Judges
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Issue Date: 15 August 2003

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In the Matter of

FRANK M. LEMON,
Claimant,

v.

Case No.: 2001-BLA-0884
(formerly 1981-BLA-4736)

ZIEGLER COAL COMPANY,
Employer, and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.
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Appearances:

Sandra M. Fogel, Esq., Culley & Wissore, Carbondale, IL
For the Claimant

Richard H. Risse, Esq., White & Risse, LLP, St. Louis, MO
For the Employer

Before: PAMELA LAKES WOOD
Administrative Law Judge

DECISION AND ORDER GRANTING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901, ***et seq.*** (hereafter "the Act"[1]). Under the Act, benefits are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners who died from pneumoconiosis. ***See*** 20 C.F.R. § 725.1(a). Pneumoconiosis,

[1] The Act was adopted as Title IV of the Federal Coal Mine Health and Safety Act of 1969, and was amended by the Black Lung Benefits Act of 1972, the Black Lung Reform Act of 1977, the Black Lung Benefits Revenue Act of 1981, and the Black Lung Benefits Amendments of 1981. The pertinent amendments are discussed in 20 C.F.R. § 725.1.

commonly known as "black lung disease," is a chronic disease of the lungs and its sequelae (including respiratory and pulmonary impairments) resulting from coal mine employment. ***See*** 20 C.F.R. § 725.101(a)(20). The instant claim is governed by 20 C.F.R. Part 727 and is currently on remand from the Benefits Review Board and the U.S. Court of Appeals for the Seventh Circuit, with development having been completed at the district director level.

Following notice to all interested parties, a formal hearing was held before me in this matter on June 24, 2003 in St. Louis, Missouri, in accordance with pertinent portions of 20 C.F.R. Part 725 and 29 C.F.R. Part 18. Each party was afforded an opportunity to present evidence and make arguments at the hearing. The parties submitted a Joint Stipulation of Evidence, dated June 24, 2002, which I have annotated to reflect the correct exhibit numbers[2] and which, as corrected, I have marked as Administrative Law Judge Exhibit 1 ("ALJ 1"). There were no witnesses. Prior to the hearing, Employer's letter motion of May 30, 2002 was granted and Employer was allowed to take the post-hearing deposition of Dr. Tuteur and to submit the transcripts for the depositions of Drs. Repsher, Dahhan, Renn, and Tuteur following the hearing. Claimant was provided with the opportunity to respond to this evidence. At the hearing, Director's Exhibits 1 through 73, Claimant's Exhibits 1 through 7, and Employer's Exhibits 1 through 14 were admitted into evidence.[3] The record was kept open until August 30 and the parties were allowed until September 30 to submit briefs, which periods were later extended. Under cover letters of June 27, 2002 and July 12, 2002, Employer submitted the transcripts of the depositions of Drs. Repsher, Dahhan, Renn, and Tuteur, which have been marked as Employer's Exhibit 15, 16, 17, and 18, respectively. Claimant submitted the supplemental report of Dr. Cohen, which has been marked as Claimant's Exhibit 8, under cover letter of September 24, 2002, and Claimant submitted his answers to interrogatories, which have been marked as Claimant's Exhibit 9, under cover letter of October 10, 2002. Claimant's brief was filed on February 28, 2003 and Employer's brief was filed on February 27, 2003. Administrative Law Judge Exhibit 1,

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[2] In Mr. Risse's June 27, 2002 letter, he requested that the numbering of the reports be corrected. As entered into by the parties, the Joint Stipulation does not include the supplemental report of Dr. Tuteur of May 30, 2002, which was marked and entered into evidence as EX 13, and it incorrectly lists the transcript of the deposition of Dr. Wiot, which was marked and entered into evidence as EX 14, as EX 13. It also lists the deposition transcripts for Drs. Repsher, Dahhan, Renn and Tuteur, as EX 14 through 17, instead of EX 15 through 18, as they were identified in counsel's June 27, 2002 letter. Those references have been corrected. In addition, the May 19, 1983 deposition transcript of Dr. Renn appears at DX 30 and the deposition transcript of Dr. Anderson appears at DX 31 (although both are listed as DX 27 on the Stipulation), and those references have been corrected as well. A reference to Dr. Cohen's supplemental report of September 23, 200[2] (CX 8) has also been added to ALJ 1.

[3] As used herein: "DX", followed by the exhibit number, designates Director's exhibits; "ALJ" designates Administrative Law Judge Exhibits; "CX" designates Claimant's exhibits; "EX" designates Employer's exhibits; and "Tr." followed by the page number references the transcript of the hearing held before me on June 24, 2002. "Claimant" refers to Claimant Frank Lemon and "Employer" refers to Employer Ziegler Coal Company. Section references are to title 20, C.F.R. unless otherwise indicated.

Employer's Exhibits 15, 16, 17 and 18, and Claimant's Exhibits 8 and 9 are now admitted into evidence. **SO ORDERED.**

The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, including all documentary evidence admitted, the testimony presented, and the applicable law.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History

Although this case has a lengthy procedural history extending over more than two decades, it is an initial claim and does not involve a modification request. Claimant Frank M. Lemon filed this application for federal black lung benefits on January 14, 1980. (DX 1). The claim was denied by a claims examiner on April 18, 1980, because the Claimant had not proven that he had pneumoconiosis, that the disease was caused at least in part by his coal mine work, or that the disease caused total disability, and the case was referred for a hearing on August 6, 1981. (DX 20). A hearing was held on March 14, 1983 before Administrative Law Judge Samuel B. Groner following which, on December 23, 1983, Judge Groner issued a Decision and Order Awarding Benefits based upon the interim presumption (appearing in former section 727.203(a)) (which was invoked by the x-ray evidence, under subsection (a)(1)) and the Employer's failure to establish rebuttal (under former section 727.203(b)). (DX 28, 32). The Employer appealed, and in a Decision and Order of September 26, 1986, the Benefits Review Board vacated Judge Groner's decision based upon his mischaracterization of the x-ray evidence and remanded the case. (DX 34). On remand, Judge Groner again awarded benefits, in a "Decision and Order on Remand – Awarding Benefits" of January 12, 1988, based again upon the x-ray evidence, after invocation of the "true doubt" rule.[4] (DX 36). Employer again appealed, and the Benefits Review Board affirmed Judge Groner's decision in an unpublished decision of December 14, 1992. (DX 39).

However, on appeal of the Board's decision, the U.S. Court of Appeals for the Seventh Circuit, by decision of May 11, 1994, "reversed and remanded for further findings before a different ALJ." (DX 40). ***Zeigler Coal Company v. OWCP***, 23 F.3d 1235 (7th Cir. 1994). The Seventh Circuit declined to reject the "true doubt" rule as contrary to the Administrative Procedure Act (as the Supreme Court later found) but limited it to "evidentiary gridlock"; it rejected Judge Groner's reliance upon the recognized progressivity of pneumoconiosis, given the lack of scientifically or medically acceptable support in the record; it questioned his distinction between various categories of B-readers; and it determined that extrinsic evidence should have been taken into consideration in evaluation of the x-ray reports. The Seventh Circuit concluded that substantial evidence did not support the decision. After vacating the decision, the Seventh

[4]In ***Director, OWCP v. Greenwich Collieries***, 512 U.S. 267, 28 BRBS 43 (CRT) (1994), the Supreme Court invalidated the "true doubt" rule, which gave the benefit of the doubt to claimants.

Circuit directed that the Claimant be given an opportunity to establish his alleged pneumoconiosis under the required standard of proof. ***Id.***

Although on September 28, 1994, the Benefits Review Board issued a remand Order, the official claims file was misplaced and did not reach the Office of Administrative Law Judges until February 11, 2000. (DX 45; ALJ 1). Because the development of evidence contemplated by the Seventh Circuit had not been completed, this matter was remanded to the district director by Associate Chief Judge Thomas Burke's Order of Remand of March 6, 2000. (DX 45). A Department of Labor examination with associated testing was conducted by Dr. Robert Cohen on September 8, 2000. (DX 58). The claim was returned to the Office of Administrative Law Judges on May 25, 2001. (DX 73).

Issues/Stipulations

The specific issues presented for resolution (DX 73; Tr. 9) are:

1. Whether the Claimant has pneumoconiosis;

2. Whether the Claimant's pneumoconiosis arose out of coal mine employment;

3. Whether the Claimant is totally disabled;[5] and

4. Whether the Claimant's disability is due to pneumoconiosis.

The parties stipulated to at least 40 years of coal mine employment. (Tr. 9). It is undisputed that Zeigler Coal Company is the putative responsible operator.

Factual Background and Medical Evidence

Background and Employment History

At the hearing before Judge Groner, Claimant and Dr. Tuteur were witnesses.[6] (DX 28). Claimant testified that he was born in 1913 and had worked for a total of 48 years as a coal miner, beginning after school at age 16, in 1929, and as a regular job two years later, continuing until January 2, 1980. (DX 28, Transcript of March 14, 1983 Hearing, at p. 16-17). All of his employment was underground, mostly at the face, and his last job was as a foreman for Ziegler Coal Company. ***Id.*** at 17-18. He also worked as a shooter, a cutting machine operator, and a

[5] The Director does not contest the issue of total disability, but the Employer does. (DX 73).

[6] Dr. Tuteur's testimony at the 1983 hearing was generally confined to the validity of a pulmonary function test taken in 1981 and a response to Claimant's testimony. (DX 28 at p. 44).

roof bolter and he performed most of the coal mine jobs at one time or another. ***Id.*** During the early years, there was hardly any air and he could hardly see the car because it was so dusty. ***Id.*** at 19. He testified that the air quality improved after 1970, when the federal law "got pretty strict." ***Id.*** He finally left the mines because he became worn out and "couldn't hardly hack it any more." ***Id.*** At the time of the 1983 hearing, he did not think he could return to his job as a foreman because of his breathing difficulties. ***Id.*** at 21. At that time, he had been experiencing symptoms for 10 to 12 years (***i.e.,*** since the early 1970's), and he had a hacking cough, became "short of wind" when he tried to climb stairs, and had difficulty sleeping through the night. ***Id.*** at 21-22. His family physician at the time was Dr. Terra, and his other doctor was Dr. Arnod from Sparta. ***Id.*** at 25, 31. Claimant testified that although he had tried cigarettes when he was younger, he never smoked regularly and did not smoke at all as of the time of the 1983 hearing.[7] ***Id.*** at 26.

In his answers to interrogatories (CX 9), Claimant indicated that he was employed in coal mining for 48 years and he was last employed as a general mine manager, a position that he held for 10 years. His duties in that job included checking and signing the mine books, assigning the foreman and workers to their duties, monitoring deliveries and construction projects, ensuring there were no safety hazards and the belts were running properly, taking care of any Federal or State citations, and generally overseeing the performance of the work. (CX 9). He explained he was "responsible for anything that happened on mine property during [his] working shift." ***Id.*** He described the heaviest part of his job as clearing rock and debris from the roadway, clearing belts and drives from coal spillage until he could "get a man to clean it up," and "walking the face while carrying all of [his] equipment." ***Id.*** He estimated that a typical shift involved sitting for one and one-half hours, walking or standing for six and one-half hours, bending off and on all day, crawling "very little," lifting 25 pounds several times daily, and carrying 30 pounds for eight hours daily. ***Id.*** During the last year of his employment, he worked six days a week, and during the last six months of his employment, he worked ten hours per day due to mandatory overtime. ***Id.*** He stated that he did not miss any time due to illness and worked until his retirement. ***Id.***

Medical Evidence

The parties have entered into a Joint Stipulation of Evidence which, as corrected, has been admitted as ALJ 1. It is incorporated by reference herein. In addition, although not noted on the

[7] At the time of his March 1980 examination, Dr. Stotlar recorded a smoking history of two packs per month for an unknown duration and noted that the Claimant "does not inhale." (DX 11). In a June 25, 1980 report, Dr. Sanjabi estimated a smoking history of no more than five pack years. (DX 24). In his October 24, 1997 examination report, Dr. Houser gave a five-pack-year history but based it upon one pack daily from age 45 to age 50. (DX 47). Dr. Renn recorded a history of sporadic, light smoking from age 11 to age 67, noting Claimant's statements that he never purchased cigarettes, did not inhale, and smoked no more than ten cigarettes in any given week. (DX 66). On September 8, 2000, Dr. Cohen reported by history that 20 years ago, the Claimant had smoked one to two cigarettes per day for three years. (DX 58). Thus, while the exact details are unclear, Claimant had a light, brief, remote smoking history.

Joint Stipulation, Dr. Tuteur testified at the previous (March 14, 1983) hearing, the transcript of which appears as DX 28.[8]

Law/Discussion and Analysis

The Supreme Court has made it clear that the burden of proof in a black lung claim lies with the claimant, and if the evidence is evenly balanced, the claimant must lose. As discussed above, in ***Director, OWCP v. Greenwich Collieries,*** 512 U.S. 267, 28 BRBS 43 (CRT) (1994), the Supreme Court invalidated the "true doubt" rule, which gave the benefit of the doubt to claimants. Now, in accordance with the Administrative Procedure Act, the proponent of a position has the burden of proof on that issue. However, as this claim was filed in January 1980, Claimant can take advantage of presumptions in the Part 727 regulations. ***See*** 20 C.F.R. §§ 718.2(b), 725.4(d) (noting Part 727 applies to claims filed prior to April 1, 1980).

The Interim Presumption.

Under the regulations at 20 C.F.R. § 727.203(a), a miner with at least ten years of coal mine employment[9] is entitled to the rebuttable presumption of total disability due to pneumoconiosis, if: (1) chest x-ray or biopsy evidence establishes the existence of pneumoconiosis; (2) ventilatory studies establish the presence of a chronic respiratory or pulmonary disease (under the criteria set forth in that subsection); (3) blood gas studies demonstrate the presence of an impairment in the transfer of oxygen (under the criteria set forth in that subsection); or (4) other medical evidence, including well-reasoned, well-documented medical reports, supports a finding of a totally disabling respiratory or pulmonary impairment. 20 C.F.R. §§ 727.203(a)(1)-(4).

Invocation under (a)(1) (x-ray or biopsy evidence). As summarized in the Joint Stipulation of Evidence (ALJ 1), there is no biopsy evidence and the x-ray evidence is split on the issue of whether the Claimant has pneumoconiosis.[10] There were two readings of the March 10, 1980 x-ray, both of which were negative for pneumoconiosis; thirteen readings of the September 14, 1981 x-ray, eleven of which were negative and two of which were positive (1/0, p and 1/1, p); eleven readings of the September 24, 1996 x-ray, eight of which were negative and three of which were positive (1/1, q/t; 1/1, p/s; and 1/0, p/s); five readings of the October 24, 1997 x-ray, two of which were negative and three of which were positive (1/0, p/q; 1/0, p/p; and 1/1, p/p); ten

[8] As reflected on the Joint Stipulation as corrected (ALJ 1), Dr. Tuteur subsequently (on February 13, 2001, May 1, 2002 and May 30, 2002) prepared three reports (DX 66, EX 12, and EX 13) and he also gave his deposition on July 9, 2002 (EX 18).

[9] As noted above, the Claimant has established at least 40 years of coal mine employment.

[10] The Joint Stipulation does not reference narrative readings that are not in compliance with the ILO system.

readings of a September 8, 2000 x-ray, six of which were negative and four of which were positive (1/0, t/q; 1/1, s/s; 1/1, p/s; and 1/0, s/p); and nine readings of a January 17, 2001 x-ray,[11] six of which were negative and three of which were positive (1/1, s/t; 1/1, p/q; 1/1, p/q). All of the readings were by NIOSH-certified B-readers, with one exception (one of the readings of the March 10, 1980 x-ray was made by a board-certified radiologist, Norman R. Shippey)[12] (DX 14). Of the twenty-five B-readers, seven interpreted the x-rays they reviewed as positive for pneumoconiosis while the others consistently gave negative readings, and the disagreement relates to all of the x-rays, except for the first (1980) one. Moreover, for each x-ray, except for the first, two or more dually qualified B-readers, who possessed the additional qualification of board certification in radiology, read the x-ray as positive while two or more dually qualified readers read the same x-ray as negative. I do not find it useful to resolve the issue by counting the number of negative readings and comparing them with the number of positive readings, as such is within the control of the parties. Inasmuch as the most qualified readers disagree as to the proper interpretation of each x-ray, I find that the x-ray evidence is in equipoise.

In its opinion in this case, the U.S. Court of Appeals for the Seventh Circuit suggested that additional medical evidence may be considered in evaluating the x-ray evidence. ***See Ziegler Coal Co. v. OWCP***, 23 F.3d 1235, 1238-39 (7th Cir. 1994) [Lemon], ***citing Old Ben Coal Co. v. Battram***, 7 F.3d 1273, 1277 (7th Cir. 1993) (explaining that the factfinder should consider the age of the readings, the qualifications of the experts, the persuasiveness of the reports, and any other relevant evidence). ***But cf. Ziegler Coal Co. v. Kelley***, 112 F.3d 839 (7th Cir. 1997) (not articulating such factfinding requirements). Thus, I note that a CT scan taken on January 17, 2001 was interpreted by Drs. Wiot and Spitz (who are dually qualified as board-certified radiologists and B-readers) as negative for pneumoconiosis and Dr. Wiot has given a deposition which discusses in some detail the interpretations of x-rays and CT scans and explains his negative findings. However, I cannot weigh the persuasiveness of the remaining B readings, including all of the positive readings, because the remaining readers did not explain their radiological interpretations to any significant extent; the readings basically appear on the Radiological Interpretation forms, which may be accompanied by an x-ray report including brief findings and an interpretation. On the other hand, Employer's pulmonary experts (Drs. Repsher, Dahhan, Renn, and Tuteur) remarked that they would not be surprised if the Claimant were ultimately found to have pathological evidence of coal worker's pneumoconiosis in view of his lengthy exposure to coal mine dust. (EX 15, p.21; EX 16, p.16; EX 17, p. 42-43; EX 18, p. 32). The other reports, test results, and depositions add little to the equation. Thus, the additional evidence neither proves nor disproves the existence of pneumoconiosis on x-ray, and I still find the evidence to be

[11] The first interpretation by Dr. Wiot of the January 17, 2001 x-ray has been excluded, because it was based upon a copy which Dr. Wiot found to be unreadable. (DX 67). He interpreted the original of that x-ray as negative, and that interpretation has been considered. (DX 70).

[12] The Joint Stipulation incorrectly listed the reader as "Shipley" instead of "Shippey," and I have corrected the annotation. (ALJ 1). Dr. Ralph T. Shipley, a B-reader and board-certified radiologist, interpreted the four later x-rays, all of which he found to be negative. (DX 65, DX 72, EX 3).

in equipoise on the issue. I therefore find that the Claimant cannot invoke the presumption under subsection (a)(1).

Invocation under (a)(2) (ventilatory studies). There are six pulmonary function tests of record, as summarized in the Joint Stipulation (ALJ 1).[13] The pertinent findings follow:

Date/ Exhibit No.	Height Recorded	FEV1 (pre- and post-bronchodilator)	MVV (pre- and post-bronchodilator)	Qualifying? §727.203(a)(2)	Comments
03/10/80 (DX 9)	70.5"	2.535	105	No	Fair[14] cooperation; good comprehension
09/14/81 (DX 26)	69.0"	2.27/2.45	107/129	No	Dr. Tepper: mild obstructive changes; response to aerosolized bronchodilator; patient cooperative and understood instructions
10/22/96 (DX 60)	69.0"	2.13	67.65	Yes, but only one tracing	Dr. Eisenstein: decreased maximal ventilatory capacity and some flow parameters, obstructive loop contour but overall pattern is mild restriction. [15]

[13] Dr. Sarah Long makes reference to other invalid studies in her report of March 15, 1983, but the studies themselves do not appear in the record. (DX 29). Similarly, in a report of September 29, 1997, Dr. Renn criticizes a September 24, 1996 pulmonary function test, and in his September 22, 1997 report Dr. James V. Vest also criticizes the September 24, 1996 test, but no test bearing that date is of record. (DX 60; ALJ 1). Dr. Renn criticizes an August 9, 2000 test, but there is none of record, and it is possible he is referring to the September 8, 2000 test. (EX 8).

[14] The parties stipulated that cooperation in the March 10, 1980 test was "fine." (ALJ 1).

[15] Dr. Eisenstein also noted insignificant change since September 24, 1996. (DX 60). As noted in footnote 13 above, the September 24, 1996 pulmonary function test is not of record. However, Dr. Eisenstein discussed the spirometry, without specific values, in his report of that date. (DX 42).

Date/ Exhibit No.	Height Recorded	FEV1 (pre- and post-bronchodilator)	MVV (pre- and post-bronchodilator)	Qualifying? §727.203(a)(2)	Comments
10/24/97 (DX 47)	67.0"	1.89/2.01	79.2/68.1	Yes	Dr. Houser: Low FEV 0.5 suggests poor initial effort. No significant bronchodilator response, mild reduction in MVV, mild restrictive and mild obstructive ventilatory impairment.
09/08/00 (DX 58)	66.0"	2.08	62	Yes	Comprehension and cooperation very good. Drs. Orbana/Cohen: probable early obstructive defect, airtrapping shown by lung volumes, reduction in diffusion due to reduction in lung volumes
02/13/01 (DX 66)	66.0"	1.76/2.04	Not recorded.	Insufficient information	Some difficulty following directions. Dr. Tuteur: minimal obstructive ventilatory defect with associated air trapping, no clear and significant improvement with bronchodilator

As discussed ***infra***, all of the recent pulmonary function tests/ventilatory studies (with the exception of the most recent one, for which insufficient information was recorded) are qualifying for any of Claimant's recorded heights under the 20 C.F.R. § 727.203(a)(2) criteria. Although I note that Claimant's height has been measured from 70.5 inches in 1980 to 66 inches in 2001, I note that loss of height may occur with age and I do not find a basis for discrediting the amounts recorded (with the possible exception of the October 1996 reading, which appears to overstate Claimant's height as compared with readings taken during the next few years). I accept the values listed on the table reproduced above as presumptively correct measurements. In any event, none of the heights would make a difference in determining whether the tests are qualifying, as the 1980 and 1981 tests would be nonqualifying for the lowest height recorded of 66" or the highest height recorded of 70.5" (or 71"), and the 1996, 1997, and 2000 tests would be qualifying for any stature from 66" through 70.5" (or 71").

The validity of some of these tests has been questioned. Pulmonary specialists Drs. Anderson, Renn and Tuteur found the September 14, 1981 test invalid for interpretation purposes on multiple grounds. (DX 27, 28, 30, 31). In April 2002, Dr. Renn remarked that the tracings from the March 10 1980 test reveal it to have been performed with poor cooperative effort and attention to technical detail, but he did not actually state that it was invalid. (EX 8). Dr. Renn found the October 22, 1996 MVV to be invalid, and he also noted the lack of an adequate number of tracings.[16] He went on to criticize all of the tests he reviewed as "suboptimal" based upon effort expended. (EX 8; EX 17 at p. 11, 49). However, he conceded that the October 24, 1997 and February 13, 2001 tests reflected acceptable effort and were valid, and he did not specifically discuss any deficiencies relating to the September 8, 2000 test. (EX 17, p. 11). Similarly, Dr. Repsher also criticized the tests as showing inadequate effort and cooperation but he only found the September 8, 2000 and February 13, 2001 tests to be "invalid for accurate interpretation." (EX 15, p. 6, 56-58). Dr. Dahhan suggested the September 8, 2000 report "technically can be considered invalid" because readings were not taken with a bronchodilator to determine whether there was reversibility. (EX 16, p. 29 to 30). That is not, however, a regulatory requirement, and Dr. Cohen has stated that "Dr. Dahhan is simply wrong to suggest that a pulmonary function study is invalid just because post-bronchodilator testing is not performed." (CX 8, p. 4.) I also note that no reviewing physician has found the October 24, 1997 test to be invalid despite the suggestion of poor initial effort.[17] I find that the September 1981 test is entitled to little if any weight based upon the consensus of criticisms submitted. I further find that the October 22, 1996 test is not in substantial compliance with the quality standards under the regulations, and the February 13, 2001 test does not contain a recorded MVV and therefore provides insufficient information for application of the Part 727 criteria; thus, these tests do not warrant consideration under subsection (a)(2). ***See generally*** 20 C.F.R. §§ 718.103(b), (c); 727.203(a)(2); 727.206(a) (2000). I find that the criticisms of the validity of the remaining tests are in the minority and do not provide a basis for invalidating the test results, although they may be considered in weighing the test results. This leaves three tests to be evaluated under the Part 727 regulatory criteria (the spirometry results of March 1980, October 1997, and September 2000).

Before discussing the regulatory criteria, I note that the Employer has argued, based upon the opinions of its experts, that "it would be an error and inaccurate and unscientific" for me to determine that the Claimant is totally disabled due to pneumoconiosis "based on pulmonary function studies only referenced to his height" in view of his advanced years. Employer's Post Hearing Brief at 53. In this regard, the criteria for invoking the interim presumption are based upon height only and do not include age. Undoubtedly, the changes made when the Part 718

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[16] On the reverse side of the pulmonary function report (DX 60 p. 30 to 31), a set of tracings appears. The Joint Stipulation merely indicates "No" under Tracings. (ALJ 1).

[17] Although Employer argues in its Post Hearing Brief that Drs. Renn and Repsher "invalidated" the October 24, 1997 pulmonary function study for less than maximum effort, such is not the case. Although invalidating other test results, Dr. Renn would only go so far as the say that the October 24, 1997 test was suboptimal (but nevertheless valid) and Dr. Repsher's comments were similar. (EX 15; EX 17).

regulations initially were adopted (with age, height, and gender specific tables) were based upon the types of considerations raised by the Employer's experts. However, the Part 727 regulations are applicable to this case, and I am constrained to follow them. ***See generally Meyer v. Zeigler Coal Company,*** 894 F.2d 902, 905-06 (7th Cir. 1990) ("If the claimant's F.E.V. [1] and M.V.V. values are the same or lower than the values specified in the table for that claimant's height, the ALJ must invoke the (a)(2) interim presumption.") The arguments raised by Employer are relevant to the issue of rebuttal of the interim presumption, but not to invocation of the presumption, as they would be tantamount to a rewriting of the Part 727 regulatory criteria. Even if such a result were deemed to be desirable, it would be outside of my ability, due to the extensive deposition testimony concerning the variable standards that could be used for assessment of predicted normals based upon age.[18]

Accordingly, I will consider the ventilatory tests based upon the regulatory criteria set forth in 20 C.F.R. §727.203(a)(2),[19] which provide a presumption of total disability due to pneumoconiosis where the ventilatory studies establish the presence of a chronic respiratory or pulmonary disease, which has lasted or is expected to last over one year,[20] as demonstrated by FEV1 and MVV values that are less than or equal to the following, for the heights specified:

Height	FEV1	MVV
67" or less	2.3	92
68"	2.4	96
69"	2.4	96
70"	2.5	100
71"	2.6	104
72"	2.6	104
73" or more	2.7	108

20 C.F.R. §727.203(a)(2) (2000).

[18] At their depositions, Drs. Renn, Repsher, Dahhan, and Tuteur discussed the different standards for predicted normals (Crapo, Capiro [sic], Morris and Knudsen) and their applicability. (EX 17 p. 30-32; EX 15, p. 32 to 35; EX 16, p. 8 to 11; EX 18, p. 38). Dr. Cohen also discussed that issue. (CX 7, 8).

[19] Although still in effect for claims such as Claimant's that were filed prior to April 1, 1980 (***see*** 20 C.F.R. §§ 718.1(b), 725.4(d)), Part 727 no longer appears in the Code of Federal Regulations.

[20] The duration and chronicity of the Claimant's respiratory impairment is apparent.

Two of the valid tests, taken on October 24, 1997 and September 8, 2000, produced qualifying values under the regulations, while the third, taken on March 10, 1980, produced nonqualifying values. In evaluating the tests that are in compliance, I find that the more recent spirometry test results are entitled to additional weight because they have more probative value on the issue of Claimant's current condition, even putting aside the issue of the progressivity of the disease (which the Seventh Circuit questioned in previous proceedings in this case). Thus, I find the 1997 and 2000 tests are more probative than the 1980 test. After weighing all of the ventilatory studies together, I find that they establish total disability under the regulatory criteria of subsection (a)(2). ***See generally Meyer, supra***. ***See also Strako v. Ziegler Coal Co.***, 3 BLR 1-136 (Benefits Review Board 1981). Accordingly, I find that Claimant may invoke the presumption under subsection (a)(2).

Invocation under (a)(3) (blood gases). As reflected on the Joint Stipulation, arterial blood gases were taken on March 11, 1980, September 14, 1981, September 24, 1996, and September 8, 2000. (ALJ 1). None of the recorded arterial blood gases are qualifying under the 20 C.F.R. § 727.203(a)(3) criteria. Accordingly, I find that Claimant cannot invoke the presumption under subsection (a)(3).

Invocation under (a)(4) (medical opinion and other evidence establishing a totally disabling pulmonary or respiratory impairment). Subsection (a)(4) requires that a miner be found to be disabled by a pulmonary or respiratory condition by a preponderance of the evidence. ***See Ziegler Coal Co. v. Kelley***, 112 F.3d 839, 842 (7th Cir. 1997. The following medical opinions have been submitted that are relevant to the issue of Claimant's degree of disability and are therefore relevant with respect to whether Claimant has established (a)(4) invocation:[21]

(1) **Gene Stotler, M.D.** examined the Claimant for the Department of Labor on March 19, 1980; recorded a history of cough and sputum for 10 years, dyspnea for five years, and chest pain, paroxysmal nocturnal dyspnea and ankle edema for two to three years; and found that the Claimant was limited to walking one to two blocks on a level surface, climbing one flight of stairs, and lifting or carrying less than 20 pounds, for the past five years. However, he attributed the disability to arteriosclerotic heart disease with angina pectoris and not to coal mining, and he did not assess the impact of these limitations upon the Claimant's ability to perform his coal mine employment. (DX 11).

[21] There are also medical records that have been submitted as well as reports that do not contain medical opinions on the issue of disability. (DX 29, 60, 66; EX 9, 10). The records include those of treating physician Dr. Teeta Pittayathikhun together with a report of July 7, 1997, but the report merely lists diagnoses (including bronchitis, pneumonitis, sinusitis, Black Lung, hypertension, edema, heart failure and diabetes mellitus), without assessing (or allocating) degree of disability. (DX 60). In addition, in a report of March 15, 1983, Dr. Sarah B. Long indicated that she was unable to determine whether Claimant was disabled based upon the information she had been provided. (DX 29). Dr. Wiot was deposed but the questioning related to interpretations of x-rays and CT scans. (EX 14).

(2) **Parviz B. Sanjabi, M.D.**, examined the Claimant on June 16, 1980. He recounted Claimant's complaints of shortness of breath when walking uphill or climbing up one to two flights of stairs, listed an impression of possible simple pneumoconiosis, and noted that the pulmonary function test was within the normal range; however, he did not otherwise comment on the disability issue and suggested further testing (specifically, arterial blood gases at rest and exercise) "for the effect of deposit of coal dust on gas exchange." (DX 24).

(3) **Arnold Tepper, M.D.**, who examined the Claimant on September 14, 1981, noted a history of dyspnea on exertion worsening over the past five to six years, previous productive cough, paroxysmal nocturnal dyspnea, orthopnea, and vague chest pain on exertion. He noted a chest x-ray positive for pneumoconiosis, category p, 1/0 (based on Dr. Brandon's interpretation). Dr. Tepper also interpreted the pulmonary function test taken on that date as showing mild obstructive changes and response with aerosolized bronchodilator but did not otherwise reach any conclusions on the disability issue. (DX 26).

(4) **William Anderson, M.D.**, a board-certified pulmonologist, reviewed the pulmonary function test results of September 14, 1981, prepared a report based upon that review on August 3, 1982, and had his deposition taken on July 1, 1983. (DX 27, 31). He opined that an individual with test results similar to that of the Claimant would "have the respiratory capacity to meet the demands of a coal miner or a similar level of work outside of mining." (DX 27; ***see also*** DX 31 p. 21-22).

(5) **Rhody D. Eisenstein, M.D.**, a board-certified pulmonologist, examined the Claimant on September 24, 1996, noted multiple medical problems by history including dyspnea with any activity (for 20 to 25 years), deconditioning, possible obstructive lung disease, possible restrictive lung disease, and questionable interstitial lung disease. Although suggesting additional testing because the Claimant's symptoms were out of proportion to the objective findings, Dr. Eisenstein did not reach any conclusions as to diagnosis or degree of disability. (DX 42). He also submitted followup reports based upon examinations of October 25, 1996 and November 12, 1996, where he again failed to reach definitive conclusions; however, he remarked upon dyspnea and deconditioning, noted mild obstructive lung disease, and suggested a possible superimposed cardiac disease. (DX 66).

(6) **William C. Houser, M.D.**, a board-certified pulmonologist, examined the Claimant on October 24, 1997, reaching an assessment which included coal workers' pneumoconiosis and mild restrictive and mild obstructive ventilatory impairment, and he noted no significant response to bronchodilator administration. He opined that the pulmonary impairment was related to coal worker's pneumoconiosis and prior exposure to coal and rock dust. Dr. Houser concluded: "I believe that he is disabled from performing any additional coal mine employment since he has evidence of coal worker's pneumoconiosis and pulmonary function impairment, he should avoid any additional exposure to coal and rock dust." (DX 47).

(7) **Robert Cohen, M.D.**, a board-certified pulmonologist, examined the Claimant for the Department of Labor on September 8, 2000. (DX 58). His cardiopulmonary diagnoses were coal worker's pneumoconiosis by chest x-ray and "COPD [chronic obstructive pulmonary disease] – secondary to coal dust exposure – early obstructive defect" and he characterized the impairment as "Minimal/early obstructive defect" with "Mild diffusion impairment." ***Id.*** In a consulting report of June 3, 2002. Dr. Cohen opined that the Claimant suffered from coal worker's pneumoconiosis and that, while his impairment was mild when adjusted for his age group, it was "disabling from the extremely heavy exertional requirements of [Claimant's] last coal mine employment." (CX 7). He also determined that Claimant's "long-term exposure to coal dust is the primary cause of his pulmonary disability as manifested by his obstructive lung defect with diffusion impairment." ***Id.*** Dr. Cohen's September 23, 2002 supplemental report [submitted on September 24, 2002 and incorrectly dated September 23, 2001] responded to the medical opinions espoused by each of the Employer's experts (Drs. Tuteur, Repsher, Dahhan, and Renn) at their depositions. (CX 8).

(8) **Peter G. Tuteur, M.D.**, a board-certified pulmonologist, examined the Claimant on February 13, 2001. He prepared an examination report (DX 66), which supplemented his earlier report based upon a review of the records (DX 66), and he also prepared supplemental reports of May 1, 2002 (EX 12) and May 20, 2002 (EX 13), and he gave his deposition on July 9, 2002 (EX 18). As noted above, Dr. Tuteur testified at the prior hearing. (DX 28). In his February 13, 2001 examination report, Dr. Tuteur determined that the Claimant "does not have clinically significant, physiologically significant, or radiographically significant coal workers' pneumoconiosis or any other coal mine dust induced disease process," that his only pulmonary problem is CT documented pleural thickening (which Dr. Tuteur attributed to a healed inflammatory process), and that Claimant had evidence of exercise intolerance in part due to instability of gait as well as exercise-associated chest pain, none of which conditions were related to coal mine dust inhalation. (DX 66). However, Dr. Tuteur concluded:

> Clearly, [Claimant] is unable to perform the tasks of a coal miner or work requiring similar effort. This disability is permanent and not expected to improve. . . .

Id. Dr. Tuteur attributed the disability to "a myriad of health problems including diabetes mellitus, arteriosclerotic heart disease with angina pectoris, degenerative joint disease, orthostatic hypotension associated with limited gait, etc." ***Id.*** In supplemental reports, he stated that the disability was due to "age, diabetes, coronary artery disease, and degenerative joint disease." (EX 12, 13). Dr. Tuteur further explained the basis for his opinions at his deposition. (EX 18). Specifically, when asked whether the Claimant could perform his last job as a general mine manager based upon his pulmonary status, he explained:

> A. Well, let's say he had pulmonary function studies that were flat out unequivocally 100 percent of predicted for an 88-year-old man. His pulmonary capacity at that level would not allow him to generate the oxygen consumption

> necessary to do heavy manual labor. And so that, no, he couldn't do general coal mining work at age 88 or 88 and a half or 87, but that inability to do so was not a result of any pulmonary dysfunction.

(EX18, p.20-21). Dr. Tuteur denied that a pulmonary disease prevented him for doing his coal mine work and opined that it "is not just because he's old, but that's a contributing factor, but also because of his diastolic dysfunction of his heart and his diabetes mellitus and the inherent vascular problems associated with it and his renal functional insufficiency." ***Id.***

(9) **Joseph J. Renn III, M.D.**, a board-certified pulmonologist, reviewed the records, prepared a report dated April 17, 2002 (EX 8), and gave his deposition on June 20, 2002 (EX 17). Dr. Renn had previously given his testimony at a deposition of May 19, 1983, but he mainly addressed the validity of the September 14, 1981 pulmonary function tests. (DX 30). In his April 2002 report, Dr. Renn reached multiple diagnoses, including mild intrinsic asthma (which he attributed to a combination of age-induced diminished pulmonary parenchymal elasticity, atherosclerotic coronary vascular disease manifested by angina pectoris, and congestive heart failure), left ventricular diastolic dysfunction, left ventricular hypertrophy owing to systemic hypertension, orthostatic hypotension, adult onset diabetes mellitus, cerebral atrophy, and diffuse idiopathic skeletal hyperostosis. (EX 8). Dr. Renn found that the Claimant did not have either medical or legal pneumoconiosis and that he was not disabled from performing his coal mining job or similar work when considering only his respiratory system, although he was disabled as a whole man. ***Id.*** He explained his opinion in detail at his June 20, 2002 deposition. (EX 17).

(10) **Abdul K. Dahhan, M.D.**, a board-certified pulmonologist, reviewed the records, prepared a report dated April 18, 2002 (EX 6), and gave his deposition on June 18, 2002 (EX 16). In his April 2002 report, he opined that Claimant had no objective findings to indicate any pulmonary impairment and/or disability based on the clinical and physiological parameters of his respiratory system.[22] (EX 6). Dr. Dahhan also noted the majority of negative x-ray readings and concluded that Claimant "has no evidence of pulmonary impairment and/or disability caused by, related to or contributed to in whole or in part, by the inhalation of coal dust or coal workers' pneumoconiosis." (EX 6). He explained at his June 18, 2002 deposition that he did not believe the Claimant to have pneumoconiosis based upon the clinical evidence but he conceded that the Claimant would be unable to do his last coal mine job due to his multiple medical problems. (EX 16, p. 2 to 3, 13, 27).

(11) **Lawrence Repsher, M.D.**, a board-certified pulmonologist, reviewed the records, prepared a report dated April 10, 2002 (EX 7), and gave his deposition on June 18, 2002 (EX 15). In his April 2002 report, Dr. Repsher opined that Claimant had no chest x-ray, pulmonary function, or arterial blood gas evidence of pneumoconiosis; his symptoms of dyspnea on exertion were "more than adequately accounted for" by his well documented coronary artery disease and

[22] In making this finding, Dr. Dahhan stated that an FVV finding of 86% of predicted and an FEV1 of 79% of predicted (based upon Dr. Cohen's examination) indicated "no respiratory impairment." (EX 6).

hypertensive cardiovascular disease, and he suffers from a number of other potentially serious medical conditions, none of which are attributable to his coal mine employment. (EX 7). At his June 18, 2002 deposition, he stated that there was "a very high likelihood" that Claimant would have "histologic simple coal workers' pneumoconiosis" (such as would be found on microscopic examination of lung tissue) even though it did not show up on x-ray, in view of his "long, long history of exposure." (EX 15 pp. 20 to 22). He also concluded that "[i]f one looks at only his pulmonary function," Claimant could "comfortably perform the job of general mine manager that he did for the last two years of his employment," but that "obviously he can't because he's got significant heart disease, plus he's over 88 years old." ***Id.*** at 23.

Looking at all of the medical opinion evidence, it is clear that, although the medical opinions from 1980 through 1983 were equivocal, the physicians expressing recent opinions (with the exception of Dr. Eisenstein, who did not squarely address the issue) generally agree that Claimant would be unable to perform his last coal mine work. Again, I find the more recent reports more probative of the Claimant's current condition. Here, there is disagreement among the six experts expressing recent opinions on the issue as to whether the Claimant has significant pulmonary or respiratory disability, and whether such pulmonary or respiratory disability as he has is disabling. Specifically, Drs. Tuteur, Renn, Dahhan, and Repsher agree that the Claimant does not have a significant pulmonary impairment but that he would be unable to perform his last coal mine job due to other factors, including his age, his diabetes, and his cardiovascular system. These physicians essentially conceded the possibility that the Claimant has a respiratory impairment, but downplayed the significance of any such impairment in view of the other factors. On the other hand, Dr. Houser and Dr. Cohen found the Claimant to have a disabling pulmonary impairment. Dr. Cohen explained that although the pulmonary function impairment was mild when adjusted for age (consisting of an early obstructive defect and mild diffusion impairment), it was disabling from the heavy exertional requirements of his last coal mine job. As noted above, the clinical evidence is equivocal, with the pulmonary function tests tending to support a finding of total disability (as measured by the Part 727 standards) while the arterial blood gases are consistently nonqualifying. At bottom, the disagreement between the experts centers upon whether the abnormalities shown on pulmonary function testing represented a true measure of Claimant's respiratory function, whether the disability reflected by such testing is attributable to other factors, and whether the disability shown is too minimal to have any significance upon the Claimant's ability to perform his last coal mine employment.

All of the physicians expressing recent opinions on this issue are highly qualified, as they are all board-certified in internal medicine with a subspecialty in pulmonary diseases and they have other impressive qualifications, as reflected on their curricula vitae; thus, I cannot select one over the others based upon qualifications. If I were to count heads, it would be two physicians finding the Claimant to be totally disabled by a pulmonary or respiratory disability and four finding him not to be so disabled. However, assessing the medical opinion evidence based upon numbers is no better than assessing the x-ray evidence on that basis. Rather, after having studied all of the opinions in detail, I find Dr. Cohen's to be the best reasoned. In this regard, he has taken into account the arduous nature of the Claimant's work, which entailed significant physical labor over

long hours, despite its fairly innocuous title of general mine manager. Due to Claimant's age and other disabilities, the limited obstructive respiratory impairment shown on pulmonary function testing would perhaps have more significance than it would on the respiratory system of a younger, healthier man. ***See generally Peabody Coal Company v. Director, OWCP***, 778 F.2d 358, 363 (7th Cir. 1985) ("The concurrence of two sufficient disabling medical causes, one within the ambit of the Act, and the other not, will in no ways prevent a miner from claiming benefits under the Act"); ***Meyer v. Ziegler Coal Co.***, 894 F.2d 902 (7th Cir, 1990) ("[T]he Act does not compensate disability due to age, it compensates disability due to pneumoconiosis caused by coal mining.") Dr. Cohen's analysis, which is based upon the impact of Claimant's respiratory impairment upon his ability to perform his coal mine job, taking into consideration his individual circumstances, makes perfect sense and calls into question the assumptions by Employer's experts that respiratory impairment of the amount measured on Claimant's spirometry is trivial or insignificant.[23] In his initial reports, Dr. Cohen explained his findings and the basis for his conclusion that the Claimant's pulmonary impairment was disabling under the specific circumstances of Claimant's case, and in his most recent report, Dr. Cohen explained why he evaluated the medical evidence differently from the other reviewing physicians. I found his discussion highly persuasive and I adopt it. Under these circumstances I find that the Claimant has established invocation under (a)(4).

Turning to section 727.203(a) as a whole, I find that Claimant has established a basis for invoking the interim presumption. For purposes of invocation, satisfying any one of the medical criteria is sufficient. ***Wise v. Peabody Coal Co.,*** 3 BLR 1-119 (1981). Thus, I find that the presumption has been invoked under subsection 727.203 (a)(2) and (a)(4) based upon the evidence now before me.

Rebuttal of Presumption. Section 727.203(b) provides, in relevant part, that the presumption in paragraph (a) will be rebutted if:

> (1) The evidence establishes that the individual is, in fact, doing his usual coal mine work or comparable and gainful work . . .; or
>
> (2) In light of all relevant evidence it is established that the individual is able to do his usual coal mine work or comparable and gainful work. . .; or

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[23] Dr. Tuteur testified at his deposition that loss of pulmonary function does not begin until function is only 65% of expected and must fall well below 50 % to be totally disabling. (EX 18, p. 14-15). See also footnote 22 above. Both Dr. Repsher and Dr. Renn testified that there is a small but measurable loss of lung function yearly, and Dr. Renn indicated that at the rate of deterioration, a person would have to be 140 to 150 years old to be disabled on a respiratory basis alone. (DX 17 p. 47; DX 15, p.17 to 19). Dr. Cohen disagreed that the loss of respiratory function was linear, and he disagreed as to the significance of a minimal obstructive ventilatory effect on a person's ability to work, particularly as applied to Claimant's situation. (CX 8, p. 3.)

(3) The evidence establishes that the total disability or death of the miner did not arise in whole or in part out of coal mine employment; or

(4) The evidence establishes that the miner does not, or did not, have pneumoconiosis.

As with invocation, one method of rebuttal is sufficient. ***See Endrizzi v. Bethlehem Mines Corp.,*** 8 BLR 1-11 (1985). The party opposing entitlement has the burden of establishing rebuttal by a preponderance of the evidence. ***See Lane Hollow Coal Co. v. Director, OWCP***, 137 F.3d 799, 803 (4th Cir. 1998); ***Peabody Coal Company v. Director, OWCP***, 778 F.2d 358, 362 (7th Cir. 1985).

Rebuttal under (b)(1) (current employment as miner). Rebuttal under subsection (b)(1) is only available if the evidence shows that the miner is "doing his usual coal mine work or comparable and gainful work." The parties agree that the Claimant retired from the mines in January 1980 and is no longer doing his usual coal mine work. (ALJ 1). Moreover, Employer concedes that rebuttal is unavailable under subsection (b)(1). Employer's Post Hearing Brief at 58. Accordingly, rebuttal under subsection (b)(1) has not been established.

Rebuttal under (b)(2) (capability to work in comparable employment). Subsection (b)(2) applies when, "[i]n light of all relevant evidence, it is established that the individual is able to do his usual coal mine work or comparable and gainful work. . . ." This case arises in the Seventh Circuit. In ***Freeman United Coal Mining Co. v. Foster***, 30 F.3d 834 (7th Cir. 1994), ***cert. denied***, 514 U.S. 1035 (1995), the Seventh Circuit interpreted the cross reference to section 410.412(a)(1) in subsection (b)(2) as incorporating the requirement that the disability be caused by pneumoconiosis. The Seventh Circuit therefore found that the standard for (b)(2) rebuttal had been satisfied when a claimant had a disabling back injury and would not have been disabled by his chronic bronchitis and emphysema independent of the back injury. ***Accord, Peabody Coal Co. v. OWCP***, 116 F.3d 207 (7th Cir. 1997).[24] As discussed above with respect to (a)(4) invocation, the medical experts recently expressing opinions in the instant case agree that the Claimant is unable to perform his last coal mine employment from a whole person standpoint, although they disagree as to whether there is any significant pulmonary or respiratory disability or whether any of such disability as exists is attributable to coal mine dust exposure. Here, as noted above, I have adopted Dr. Cohen's opinion that the Claimant has a totally disabling pulmonary or respiratory impairment, over the opinions to the contrary. If the Claimant has established total disability due to a pulmonary or respiratory condition, ***a fortiori***, the Employer has failed to establish the contrary. I also adopt Dr. Cohen's determination that Claimant's pulmonary or respiratory impairment is due to clinical and legal pneumoconiosis resulting from his over 40 years of

[24] This rule is contrary to that of other Circuits, including the Fourth Circuit, where (b)(2) rebuttal is only available when it has been demonstrated that a miner is capable doing his usual coal mine or comparable gainful work from a "whole man" standpoint. ***See, e.g., Grigg v. Director, OWCP,*** 28 F.3d 416, 418 (4th Cir. 1994).

underground coal mine employment. As discussed under (b)(3) rebuttal, below, I reject the assertion that Claimant's disability is entirely due to causes other than pneumoconiosis for the reasons stated below. Accordingly, I find that rebuttal under subsection (b)(2) has not been established.

Rebuttal under (b)(3) (no causal relationship to coal mine employment.) To establish rebuttal under subsection (b)(3), the party opposing entitlement must show that "the total disability or death of the miner did not arise in whole or in part out of coal mine employment." 20 C.F.R. § 727.203(b)(3). Again, the U.S. Court of Appeals for the Seventh Circuit has adopted a specific standard. In the Seventh Circuit, the inquiry under subsection (b)(3) is whether the miner would have been disabled notwithstanding his pneumoconiosis and, if so, the presumption of total disability has been successfully rebutted. ***Ziegler Coal Company v. Kelley,*** 112 F.3d 839, 843 (7th Cir. 1997). To establish rebuttal, the employer must show by a preponderance of the evidence that black lung disease was not a contributing cause, defined as a cause necessary, but not necessarily sufficient, to bring about the miner's disability. ***Id.*** at 844, ***citing Peabody Coal Co. v. Vigna***, 22 F.3d 1388 (7th Cir. 1994). ***See also Peabody Coal Co. v. Estate of Goodloe***, 299 F.3d 166 (7th Cir. 2002). In ***Amax Coal Co. v. Beasley***, 957 F.2d 324, 327 (7th Cir. 1992), the Seventh Circuit stated that the employer must "rule out" pneumoconiosis by a preponderance of the evidence to establish (b)(3) rebuttal, and in ***Amax Coal Co. v. Director, OWCP***, 312 F.3d 882 (7th Cir. 2002) [Chubb], the Seventh Circuit explained that the employer must show that the disability was caused entirely by an impairment other than pneumoconiosis.[25] Noting that the employer's burden under (b)(3) is "an uphill battle," the Seventh Circuit found that negative x-rays were insufficient as a matter of law to establish rebuttal, that a death certificate not mentioning pneumoconiosis did not "rule out" pneumoconiosis as a partial cause, and that conclusory or equivocal medical statements were properly rejected as insufficient. ***R & H Steel Buildings v. Director, OWCP***, 146 F.3d 514, 519 (7th Cir. 1998). In ***Freeman United Coal Mining Co. v. Director, OWCP***, 20 F.3d 289 (7th Cir. 1994), the Seventh Circuit found that a physician's statement that the miner's pneumoconiosis did not contribute "significantly" is insufficient as it does not exclude "the possibility that it contributed in some, presumably lesser, degree."

While certain of the experts may have disagreed, as discussed above, I find that the medical evidence as a whole falls short of ruling out pneumoconiosis as a contributing cause to

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[25] As so articulated, the Seventh Circuit standard is not significantly different from that of the Fourth Circuit, which has interpreted the "in part" language in subsection (b)(3) to require that the employer rule out the causal connection between the miner's total disability and his coal mine employment either by positive evidence demonstrating that the miner suffers from no respiratory or pulmonary impairment or by evidence attributing any impairment present solely to sources other than coal mine employment. ***Lane Hollow Coal Co. v. Director, OWCP***, 137 F.3d 799, 804-05 (4th Cir. 1998). ***See also Island Creek Coal Co. v. Holdman***, 202 F.3d 873 (6th Cir. 2000) (physician's opinion that is equivocal regarding the etiology of the miner's respiratory impairment is insufficient to satisfy the "rule out" standard.)

Claimant's disability. I find that the preponderance of the evidence discussed above, when considered as a whole, establishes that the Claimant had a measurable respiratory impairment that contributed to his total disability. My basis for finding a total pulmonary or respiratory disability is discussed in my analysis of (a)(4) invocation above.

I also find that the medical opinion evidence attributing the Claimant's impairment solely to sources other than coal mine employment is insufficient for rebuttal, as the medical opinions list various possible contributing factors without attempting to attribute significance to any one of them and without explaining how these factors played a part in causing Claimant's disability. The reports of Drs. Tuteur, Renn, Repsher, and Dahhan, discussed above, are all deficient in this manner. Despite the volume of paper generated by these physicians, their reports and the opinions articulated at their depositions are either equivocal or essentially conclusory on the matters that are relevant to (b)(3) rebuttal.

As Dr. Cohen noted in his initial report, after noting the various diagnoses to which the Employer's experts vaguely attribute Claimant's disabilities:

> . . . There is no evidence that these other medical conditions have caused his impairment. It is important to note that no additional cardiac testing or procedures were required and that Mr. Lemon is not receiving treatment for any such condition. There is simply insufficient information in his medical records to substantiate that these other conditions are significant health concerns or that they are significant enough to be causing pulmonary dysfunction.

(CX 7 p. 18). Despite Dr. Renn's suggestion to the contrary, Dr. Cohen persuasively explained that the Claimant's partial response to bronchodilators and possible asthma does not rule out pneumoconiosis as a cause of Claimant's respiratory disability, as the evidence does not support a diagnosis of asthma, the Claimant could have both conditions, and asthma can be related to coal dust exposure. (EX 8).

I also reject the suggestion made by Dr. Tuteur that he can state within reasonable medical certainty that no obstructive ventilatory impairment resulted from the Claimant's 40 plus years of coal mine employment because obstruction so rarely results from coal mine dust exposure. Again, I rely upon Dr. Cohen's thoughtful, reasoned analysis of the epidemiological evidence in his reports, and its application to the instant case, which I adopt. (CX 8, 9).

In view of the above, I find that the medical opinion evidence falls short of ruling out coal mine dust as a contributing factor to the Claimant's total disability, and the other evidence of record does not do so either. Thus, I find that the evidence taken as a whole does not rule out the causal connection between the miner's total disability and his coal mine employment, and Claimant has failed to establish (b)(3) rebuttal.

Rebuttal under (b)(4) (no pneumoconiosis). Finally, there can be no rebuttal under subsection (b)(4), relating to evidence establishing that the Claimant did not have pneumoconiosis. As noted above, I have found the x-ray evidence to be in equipoise. Therefore, just as it did not support the invocation of the interim presumption, it does not support rebuttal. Similarly, the medical experts disagree as to whether the Claimant either has coal worker's pneumoconiosis (clinical pneumoconiosis), or another respiratory condition (such as COPD or asthma) caused or aggravated by coal mine dust exposure (legal pneumoconiosis). The medical opinions as to CWP (or clinical pneumoconiosis) are premised in part upon the x-ray evidence, so to the extent that the x-ray evidence is in equipoise, so too are those opinions. In addition, as discussed under (a)(1) invocation above, each of Employer's expert witnesses conceded the possibility that the Claimant had clinical pneumoconiosis that did not show up on the x-rays. Turning to legal pneumoconiosis, for the same reason that I found the evidence to fall short of ruling out coal mine dust as a contributing or aggravating factor with respect to Claimant's respiratory impairment, I find it to fall short of establishing that the Claimant does not have legal pneumoconiosis. Again, I find Dr. Cohen's discussion of the epidemiological evidence relating to the association between obstructive ventilatory defects and coal mining to be most persuasive. Thus, I find that the evidence does not establish that the Claimant "does not, or did not, have pneumoconiosis" so as to give rise to (b)(4) rebuttal.

Conclusion

In view of the above, I find that the Claimant has established a basis for invocation of the interim presumption under subsections (a)(2) and (4) of section 727.203 and that rebuttal has **not** been established under subsections (b)(1) through (4). Claimant is therefore entitled to benefits and it is unnecessary to consider whether he could establish entitlement under the other pertinent regulations.

Effective Date

I have found a basis for invocation under subsection 727.203 (a)(2) and (4), based upon a the ventilatory studies (pulmonary function tests) and medical opinions rendered beginning in 1997. However, as shown by the Joint Stipulation (ALJ 1), there is a period of time between 1981 and 1996 when the medical evidence is sparse and does not provide good data on the Claimant's degree of disability. From the record before me, I am unable to determine whether the Claimant's total disability manifested itself prior to October 1997. Accordingly, I find that benefits should commence as of January 1, 1980, the month the claim was filed. ***See*** 20 C.F.R. § 725.503(b).

ORDER

IT IS HEREBY ORDERED that the claim of Frank M. Lemon for benefits under the Act, commencing as of January 1, 1980, be, and hereby is, **GRANTED.**

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PAMELA LAKES WOOD
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on the Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.